Connecticut Employer Application

FOR GROUP COVERAGE (GROUPS WITH 2 – 100 ELIGIBLE EMPLOYEES*)

PPO and Indemnity plans are underwritten by Aetna Life Insurance Company. DMO and PPO dental plans are underwritten by Aetna Life Insurance Company.

Company Name (Legal Name)	DBA/Doing Business As (if applicable)		
Street Address (PO Box not acceptable)	City	State	ZIP
Billing Address (if different than above)	City	State	ZIP
Phone Number ( )	Fax Number ( )		
Are there additional addresses/locations for this business? ☐ Yes ☐ No If "Yes," provide all addresses and locations.			

Company Contact – Name and Title		Company Contact E-mail Address	
Billing Contact Name (if different from Company Contact) *Go green – online statements available. Activate access to your eBusiness account at www.aetna.com/employersregister upon receipt of your approval letter.*		Billing Contact E-mail Address	
Enrollment Contact Name (if different from Company Contact)		Enrollment Contact E-mail Address	
SIC Code	Nature of Business	Federal Tax ID Number	Date Business Established (Mo/Yr):
Employer Classification ☐ Corporation ☐ Non-Profit ☐ Partnership ☐ Sole Proprietor ☐ LLC ☐ LLP ☐ Other: _____			

Effective Date of Group Plan

Actual effective date will be assigned by the Aetna underwriting department if the application is approved.

Requested effective date (may be the 1st or the 15th of the month only). _____

Medical Coverage Selection

☐ Open Choice PPO – Plan Option: _____

☐ Aetna Indemnity – Plan Option: _____

A. 51 to 100 eligible employees: If you have selected an HSA-compatible plan:
- Do you plan to make contributions to your employees' HSA accounts? ☐ Yes ☐ No
- Do you plan to offer your employees payroll deductions to fund their HSA accounts? ☐ Yes ☐ No

B. 51 to 100 eligible employees: Do you, or any third party on your behalf, in any way fund or subsidize any portion of the member's cost sharing responsibilities (deductibles, coinsurance or copays) under a high deductible health plan (HSA or HRA)? If "Yes," how much? _____ % ☐ Yes ☐ No

C. Does this group have a flex plan under Section 125 of the Internal Revenue Service code? ☐ Yes ☐ No

Dental Coverage Selection

Aetna Dental® Plan

Standard Plans:
Option: _____

Voluntary Plans:
Option: _____

Orthodontia coverage is available in some plans for dependent children in groups with 10 or more eligible employees with a minimum of 5 enrolled employees.

Please keep a copy of this application for your records. If the application is accepted by Aetna, it becomes part of the issued Group Agreement and/or Group Policy.

Life, Short Term Disability, and Packaged Life/Disability Coverage Selections

- Groups of 2 to 9 eligible employees are limited to one class.
- Groups with 10 to 50 eligible employees may select one, two or three options for Life, Short Term Disability, and Packaged Life & Disability, with a minimum requirement of 3 employees in each option. If more than one option is selected, describe each class of employees, indicate the amount selected for each class and attach a list of employee names with each class designation. (Limited to 3 classes. The highest option selected can be no more than 5 times the lowest option.)
- Groups of 51 to 100: contact your Aetna Sales Executive.

Groups with 2 to 50	☐ 10,000	☐ 15,000	☐ 20,000	☐ 50,000
Groups with 10 to 50	☐ 10,000 ☐ 75,000	☐ 15,000 ☐ 100,000	☐ 20,000 ☐ 125,000	☐ 50,000
Life & Disability Packaged Plan	☐ Low	☐ Medium	☐ High	
Short Term Disability	☐ Option 1	☐ Option 2	☐ 100 ☐ 200 ☐ 300 ☐ 400 ☐ 500	
Class Description	Class 1	Class 2	Class 3	
Optional Dependent Term Life (available only to groups with 10 to 50 eligible employees): ☐ Yes ☐ No				

Employer Contribution(s)

	Medical	Dental	Employee Life	Dependent Life	Packaged Life and Disability	Disability
Employer Contribution for Employee	%	%	%	N/A	%	%
Employer Contribution for Dependent	%	%	N/A	%	N/A	N/A
Employee Disability Tax Contribution - check one: ☐ Pre-Tax ☐ Post-Tax						

Business Eligibility

Is your company a subsidiary of another company; an affiliate of another company; or under common control with another company?	☐ Yes ☐ No
Does your company file state or federal taxes with another company(ies) on a combined or consolidated basis?	☐ Yes ☐ No
Are there any associated companies to be included with this group that are commonly owned?	☐ Yes ☐ No

If "Yes" to any questions, complete the information below. *(If additional space is needed, attach a separate sheet.)*

- A copy of the Quarterly Wage and Tax Statement must be provided for each group to be included for coverage.
- If you file or are eligible to file multiple businesses under one tax ID number, all businesses must be included as one group.

Business Name	Tax Identification Number	Owner's Name	Percentage of Ownership	Number of Employees	Is group to be included?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

If you have answered "No" to "Is the group to be included" above, please explain why.

Is your company a branch of another company? Does your company have branch offices?	☐ Yes ☐ No
If "Yes" - Is each branch office a separate legal entity?	☐ Yes ☐ No
- Is each branch a location of one legal entity?	☐ Yes ☐ No
- How many branch offices are there?	
- Are taxes filed separately or as one common filing?	

- Where is each branch located? (List each branch business address separately.)	Number of Employees at each location

Do you use the services of a Payroll Company? If "Yes," provide the name of the payroll company.	☐ Yes ☐ No
Are you currently a client of a Professional Employer Organization (PEO)?	☐ Yes ☐ No
If "Yes," is this an Aetna PEO? Aetna group #: _____ (A letter of intent is needed for 51+ groups.)	☐ Yes ☐ No
Is group coverage available to you as a client of the PEO?	☐ Yes ☐ No
Are you considered a Co-Employer with the PEO?	☐ Yes ☐ No
By enrolling for coverage, I am not in violation of any contractual breach of contract with the PEO.	☐ Agree ☐ Disagree

Employee Eligibility

Work Location (list by state)	Number of Employees						
	Full-time	Part-time	Retired	COBRA	1099	Union	Other (e.g., temporary, substitute, seasonal)
TOTAL							

Of the total number of eligible employees indicated above, how many are:	
- currently in the waiting period and not eligible?	
- currently waiving medical coverage?	

Number of hours per week to be eligible for coverage _____ Excluded Classes: ☐ None ☐ Union – Local # _____

Benefit Waiting Period

Eligibility date for enrollment will be the first day of the policy month following the waiting period, except 90 days exact. Policy month refers to the contract effective date of the 1st or 15th.

Waive the waiting period for present employees enrolling with the group (even those who have not met the full waiting period)? ☐ Yes ☐ No

Waiting Period for future employees:

☐ First day of policy month following: ☐ 0 Days ☐ 30 Days ☐ 60 Days

☐ Exactly 90 Days following Date of Hire

If "0 days" is selected and the employee is hired on the 1st day of the month, the effective date will be the date of hire.
If "Exactly 90 days" is selected, the enrollment eligibility date will begin 90 calendar days following the date of hire.

Is a dual waiting period offered? If "Yes," provide the two classes of employees below: ☐ Yes ☐ No

Class 1 Name: _____ Class 1 Waiting Period: _____

Class 2 Name: _____ Class 2 Waiting Period: _____

Medicare Primary versus Secondary

Is your group Medicare Primary (employed less than 20 employees for 20 consecutive weeks in the current or prior year) or Aetna Primary (employed 20 or more employees for 20 consecutive weeks in the current or prior year)? *Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers* *Exclude: Self-employed persons, Independent contractors (1099), Directors*	☐ Medicare Primary ☐ Aetna Primary
How many full-time and part-time employees have you employed for at least 20 or more weeks during the current or prior calendar year?	
100 or More Employees – Disabled Provision: How many full-time and part-time employees did you employ on 50% or more of your business days during the prior calendar year?	

Affordable Care Act (ACA) Medical Loss Ratio Requirement

What is the average number of employees you employed for the entire previous calendar year regardless of whether or not they were eligible for coverage? An employee is defined as any person for whom the company issues a W-2, including full time, part-time, and seasonal workers, and regardless of insurance eligibility.	

COBRA/TEFRA/DEFRA

Is your employer group required to comply with COBRA regulation?	☐ Yes ☐ No
How many full and part-time employees did you employ 50% of the business days in the prior calendar year? *Include: Full-time, Part-time, Seasonal, Temporary, Union, Owners, Partners, Officers* *Exclude: Self-employed persons, Independent contractors (1099), Directors* Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours that the part-time employee worked divided by the hours an employee must work to be considered full-time.	
Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? If "Yes," enter information below. Attach a separate sheet, if necessary.	☐ Yes ☐ No

Name of Applicant	Qualifying Event (e.g., termination of employment, divorce, etc.)	Date of Qualifying Event	Date COBRA or StateContinuation Coverage Terminates

Medical Information

Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently receiving Workers' Compensation benefits?	☐ Yes ☐ No
Is any person currently on leave of absence? If "Yes," provide start date and expected date of return below.	☐ Yes ☐ No
If "Yes" is answered to any of the above, provide names of the individual(s) and details.	

Prior Carrier Information

If the Aetna plan is replacing an existing medical and/or dental plan, be sure to submit a copy of the most recent bill with employee roster. For dental, also include the benefit summary.

Is this plan total replacement of any existing group plans?		Carrier Name	Phone Number	Start Date	End Date
Current Medical Carrier	☐ Yes ☐ No				
Current Life Carrier	☐ Yes ☐ No				
Current Disability Carrier	☐ Yes ☐ No				
Current Dental Carrier	☐ Yes ☐ No				

Current Dental Coverage, check all that apply: ☐ Major Services ☐ Orthodontia – Ortho Max $ _____ ☐ Discount Dental

Number of carriers within past 5 years? _____

Has your business ever been insured with Aetna? If "Yes," provide group number: _____ ☐ Yes ☐ No

Workers' Compensation

Does company offer Workers' Compensation?	☐ Yes ☐ No
Is any person to be covered unable to work due to illness or injury?	☐ Yes ☐ No
Is any person currently receiving Workers' Compensation benefits?	☐ Yes ☐ No
Is any person currently on leave of absence? If "Yes," provide start date and expected date of return below.	☐ Yes ☐ No
If "Yes" is answered to any of the above, provide names of the individual(s) and details.	

Early Retirees for Group Size 51 to 100

How many are younger than age 65? _____	How many are older than age 65? _____
Are they offered the same benefits as full-time? ☐ Yes ☐ No	

Signature Section

The Applicant agrees that at no time shall any employee be permitted or required to contribute for non-contributory coverage; or, unless the change is approved in writing by an authorized representative of Aetna, to make contributions for contributory coverage at a rate higher than the initial contribution rate applicable for the employee's then current coverage. It is agreed that no coverage shall become effective as to any person who is not then a bona fide, full-time employee, regularly performing the duties of his or her occupation (subject to applicable HIPAA requirements for health coverage), unless otherwise specifically provided in the plan documents (which consist of the Group Agreement and/or Group Policy). All statements herein shall be deemed representations and not warranties.

The Applicant acknowledges that it has selected this plan based upon written information provided by Aetna and that no broker, agent or consultant is authorized to modify the terms of the offer or to agree to changes. All material terms of plan coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to employee's coverage under the Group Agreement or Group Policy available to Aetna for inspection, at Aetna's expense, at Applicant's office, during regular business hours, upon reasonable advance request. This provision shall survive termination of the Group Agreement or Group Policy.

Applicant has selected, in accordance with applicable state law, the plan to be offered to Applicant's employees and Applicant has solely determined any/all health plan options for the Applicant's employees and the contribution amounts.

Information on agent's compensation is available from your agent or at Aetna.com.

In accordance with current IRS regulations and the 1986 Tax Reform Act, a life insurance position schedule may be deemed discriminatory and result in imputed income tax to certain employees and possibly an excise tax to employers. Employers should consult with legal counsel prior to electing a position schedule. Aetna disclaims any responsibility if the employer elects such a position schedule and it is later deemed discriminatory.

The plan documents will determine the contractual provisions, including procedures, exclusions and limitations relating to the plan and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.

With the exception of Aetna Rx Home Delivery®, participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc.

Applicant agrees to deliver, or otherwise make available to enrollees, all Aetna paper or online member documents and other plan-related materials upon request by Aetna.

continued on next page

Signature Section *(Continued)*

Employer Acknowledgment – Employer Waiting Period

Starting with plan years on or after 1/1/2014, the Affordable Care Act and subsequent federal regulations prohibit group health plans and health insurance issuers from requiring any otherwise eligible plan participants and beneficiaries (employees and dependents) to wait more than ninety (90) days before their health coverage is effective. The regulations define group health plan as the employer or plan administrator. The issuer is defined as the insurance company. Since the requirement applies to both the group health plan and the issuer, each party's obligation is satisfied if the ninety (90) day waiting period is honored. However, if neither party complies, both are subject to penalty.

The Employer Group Policyholder ("Employer") represents that it provides to Aetna, effective date information regarding plan participants and beneficiaries that takes into account the eligibility conditions and waiting period requirements required under federal law, in order for such plan participants and beneficiaries to become eligible for coverage under the Employer's group health insurance coverage with Aetna. In compliance with the waiting period requirements, Aetna shall use the effective date information provided by Employer to enroll such plan participants and beneficiaries in the Employer's group health insurance coverage. In the event this information changes, the Employer shall inform Aetna immediately.

ELECTRONIC ENROLLMENT, BILLING/PAYMENT AND ACCESS AGREEMENT

Enrollment: As part of your participation date, the following terms and conditions apply:

1. You agree to keep copies (paper or electronic) of actual enrollment forms and agree to maintain a reasonably complete record of enrollment and eligibility information (via electronic, interactive voice response technology and/or hard copy format), including evidence of coverage elections, evidence of eligibility, changes to such elections and terminations. Records must be available to Aetna upon request and retained for seven years.
2. For electronic enrollment submissions or changes you agree to create and maintain the records on secure information systems that can generate hard copy records of enrollments or changes entered or maintained on those information systems. Any hard copy records generated pursuant to this provision shall meet reasonable standards of availability, authenticity, non-repudiation and integrity.
3. You represent that all enrollment and eligibility information presented to Aetna is accurate and timely updated. You acknowledge that Aetna can and will rely on such enrollment and eligibility information in determining whether an individual is eligible for benefits under the plan. In the event of a discrepancy between enrollee information (including salary data) submitted and information actually presented by the enrollee on any particular claim for benefits, and the result is that Aetna must pay a higher benefit to reflect the actual information presented by the enrollee, you agree to pay promptly to Aetna applicable back premiums accruing as of the date on which the enrollee's information changed.
4. Insured plans must either (1) use Aetna-supplied forms in paper format or electronic format or (2) agree to incorporate the following four points into your enrollment materials.
   a. Names(s) of the Aetna company offering the insurance coverage
   b. State-specific fraud warning statement
   c. A statement that the terms of the insurance documents will govern the member's rights and responsibilities
   d. An acknowledgment that participating providers are not agents or employees of Aetna and that network composition can change.
5. You are responsible for adhering to both state and federal laws and regulations when submitting terminations to Aetna.
6. If otherwise permitted, when retro-terminations are submitted, we will regard the submission as verification that no premium/contribution was paid by the member/dependent for that period.

Billing/Payment: You agree to receive your bill online each month. Any contractual provisions related to non-payment of premium continue to be applicable. I/we understand and agree to the terms set forth in this Agreement. By signing below, I represent that I am authorized to sign this Agreement.

Access: Plan sponsor agrees that each employee will agree to terms associated with the issuance and use of his/her password and system access. An individual's password may be used only by that individual to access the system and may not be shared for any reason. Each individual is personally responsible for the information entered into the system. If an individual to whom a password has been issued becomes aware of a security breach (an incident in which there occurs attempted or unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations), they agree to contact Aetna.

SUMMARY OF BENEFITS - PLEASE READ AND CHECK BELOW TO CONFIRM:

☐ In accordance with my contract with Aetna to distribute information related to enrollment/coverage information, I have received the Summary of Benefits and Coverage document associated with the plan information referenced in this application. I confirm I will provide SBCs to plan participants and beneficiaries in compliance with the federal regulation and guidance related to SBCs, including the requirements for timing and delivery.

Signed at City, State	Applicant (Company Name)	
Authorized Applicant Signature	Official Title	
Print Name of Authorized Applicant		Date

Agent/Broker Certification

I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk, for all products being applied for, including life insurance, if applicable.

I hereby certify that I am licensed and appointed to sell Aetna products in the state of Connecticut.

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notice from Aetna that the coverage being applied for by this application is accepted.

Agent/Broker Name:				
SSN:		National Producer Number:		
Agency Name:		TIN:		
Pay Commissions To (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of Credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail Address:		
Agent/Broker Name:				
SSN:		National Producer Number:		
Agency Name:		TIN:		
Pay Commissions To (check one): ☐ Broker ☐ Agency		Phone: ( )	Fax: ( )	
Address:		City:	State:	ZIP:
Signature:	Date:	E-mail Address:		% of Credit:
Broker Admin Assistant Name:		Broker Admin Assistant E-mail Address:		
General Agent Name:		TIN:		
Selling Agent Name:		E-mail Address:		
Phone: ( )		Fax: ( )		
Address:		City:	State:	ZIP:
GA Admin Assistant Name:		GA Admin Assistant E-mail Address:		